

APPLICATION FOR APPROVAL OF CONTINUING EDUCATION COURSE
Course Attendee

Continued competency means a planned learning experience relating to the scope of physical therapy practice as defined by KRS 327.010(1) if the subject is intervention, examination, research, documentation, education or management of health care delivery systems. For guidelines on continued competency see [APTA's Policy on Professional Development, Lifelong Learning and Continuing Competence](#).

Name: _____ Kentucky License #: _____

Address: _____

City/State/Zip: _____ Phone: _____

Fax: _____ E-Mail: _____

Exact Program Title:

Program Format:	<input type="checkbox"/> Lecture/Lab	<input type="checkbox"/> Video	<input type="checkbox"/> Correspondence	<input type="checkbox"/> Online	<input type="checkbox"/> Other
Key Word/Category: (Please select all that apply)	<input type="checkbox"/> Acute Care	<input type="checkbox"/> Aquatic Physical Therapy	<input type="checkbox"/> Cardiovascular & Pulmonary		
	<input type="checkbox"/> Clinical Electrophysiology	<input type="checkbox"/> Documentation	<input type="checkbox"/> Education		
	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Hand Rehabilitation	<input type="checkbox"/> Health Policy & Administration		
	<input type="checkbox"/> Home Health	<input type="checkbox"/> Management	<input type="checkbox"/> Neurology		
	<input type="checkbox"/> Oncology	<input type="checkbox"/> Orthopaedic	<input type="checkbox"/> Payment Policy		
	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Private Practice	<input type="checkbox"/> Research		
	<input type="checkbox"/> Sports Physical Therapy	<input type="checkbox"/> Women's Health	<input type="checkbox"/> Wound Management		

Intended Audience: ☐ PT ☐ PTA ☐ Students ☐ Other (specify) _____

Has this program been approved for Continuing Education by another agency or association?

☐ No ☐ Yes (if yes please specify)

Date Approved _____ Agency _____

Contact Hours: (excluding meals and breaks) _____

The following information must accompany this application: (attach course brochure if inclusive of information listed below). Failure to include requested documentation may result in application being delayed or rejected.

1. Timed Outline or Agenda
2. Course Description
3. Course Objectives
4. Home-study or online courses must submit a copy of the post-test and the minimum passing score
5. Biographical data for each speaker to include pertinent educational and clinical experience
6. Application fee of \$10.00
7. Include a self addressed, stamped envelope for reply
8. Describe how this information will be utilized in your Physical Therapy Practice:

Signature: _____ Date: _____

Return to: **KPTA, P.O. Box 109, Verona, KY, 41092, Phone/Fax: (859) 485-2812, kptaky@gmail.com**

Do not write below this line:

For Office Use Only:

Denied

Reason _____

Approved

KPTA Approval # _____

Approval Expiration Date _____

Approval Committee Signature: _____ **Date:** _____

